ATRIAL FIBRILLATION CLINIC REFERRAL FORM

LRH AF Clinic Fax: **5173 8097** or Via Argus – **argusmessengercs34@lrh.com.au** for triage
Enquiries: **PH : 51738111 OR 51735505** to speak with RAAFC co-ordinator/nurse

Referral Date:

Patient details *(If LRH inpatient attach Bradma)*

Name:	
DOB:	
Address:	
Phone:	
Medicare:	

Referring Practitioner details:

Referrer's name:	
Provider number:	
Clinic:	
Address:	
Phone/Fax:	

Step 1: Eligibility Criteria: ***(Please ensure your patient meets ALL criteria before proceeding with referral):***

New diagnosis Atrial Fibrillation, recent exacerbation of Atrial Fibrillation, OR recent exacerbation of Congestive Cardiac Failure with associated Atrial Fibrillation
Patient an appropriate candidate for therapeutic intervention
Patient NOT known to alternative Cardiologist

Step 2: Reason for Referral

◯ New diagnosis Atrial Fibrillation
◯ Recent exacerbation of Atrial Fibrillation
◯ Recent exacerbation of Congestive Cardiac Failure with associated Atrial Fibrillation

Please attach the following required information:

◯ Medical history including current medications and allergies
◯ Recent Echocardiogram (If not done, please refer TTE through LRH Cath Lab, AF clinic has pre-arranged time slots per week)
◯ If able, arrange 24hr holter to be fitted PRIOR to discharge, refer through allied health.
◯ Relevant pathology and radiology results
◯ Recent blood tests (FBE, Hba1c, UEC, lipid profile, TSH)
◯ Other health professionals involved in management including Endocrinologist, Cardiologist or General Physician

Step 3:

Fax or email this referral form to the number at the top of the form.
Atrial Fibrillation Clinic will contact patient to arrange appointment.
Ineligible referrals will be returned to referring practitioner.